7.02: continued

(a) determined to be an emergency by a medical professional in charge of the patient, and are so classified in the patient's hospital record pursuant to hospital's manual or document described in 117 CMR 7.03(1)(b); or
(b) inpatient medical care services which are associated with and follow immediately the emergency care as described in 117 CMR 7.02(1); or
(c) screening of patients presenting themselves for unscheduled treatment, in those cases which are ultimately determined not to qualify under 117 CMR 7.02(1), to the extent that such screening is required by law.

Federal Poverty Income Guidelines. The federal poverty income guidelines used as an eligibility criterion by the federal Department of Health and Human Services.

Fiscal Year. The time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the immediately following calendar year.

Free care. Any unpaid hospital charges for:
(a) emergency care to uninsured patients, for which the costs have not been collected after reasonable collection efforts; or
(b) medically necessary services to patients who are exempt from collection action pursuant to 117 CMR 7.08 and who have been deemed, pursuant to the hospital's credit and collection policy, financially unable to pay for all or part of the hospital care rendered to the patient; or
(c) medically necessary services to patients in situations of medical hardship where major expenditures for health care have depleted or can reasonably be expected to deplete the financial resources of the individual to the extent that medical services will be unpaid;
(d) any unpaid charges for services rendered to participants in the Medicare program shall not be deemed free care charges eligible for payment from the pool except to the extent that such charges
1. satisfy the requirements of 117 CMR 7.02: Free care(a) and (b), and
2. were properly submitted for payment to the Medicare intermediary and were rejected by such intermediary as failing Medicare substantive rules.

Gross Patient Service Revenue. The total dollar amount of hospital's charges for services rendered in the fiscal year.

Guarantor. A person or group of persons who assumes the responsibility of payment of (all or part of) the hospital charges for services, but not including third party payers.

Health Insurance Company. A company as defined in M.G.L. c. 175, § 1, which engages in the business of health insurance.

Health Insurance Plan. The medicare program or an individual or group contract or other plan providing coverage of health care services which is issued by a health insurance company, a hospital service corporation, a medical service corporation or a health maintenance organization.

Health Maintenance Organization. Company which provides or arranges for the provision of health care services to enrolled members in exchange primarily for a prepaid per capita or aggregate fixed sum as further defined in M.G.L. c. 176G, § 1.

Healthy Kids. A program of preventive pediatric health care services for certain children, from birth to age six, administered by the Department pursuant to M.G.L. c. 118F, § 17A.

Healthy Start. A program of health care, designed to lower the infant mortality rate, administered by the Department of Public Health pursuant to M.G.L. c. 111, § 24D.

Hospital. An acute hospital.

7.02: continued

Hospital Service Corporation. A corporation established for the purpose of operating a nonprofit hospital service plan as provided in M.G.L. c. 176A.

Managed Health Care Plan. A health insurance plan which provides or arranges for, supervises and coordinates health care services to enrolled participants, including plans administered by health maintenance organizations and preferred provider organizations.

Medicaid Program. The medical assistance program administered by the department of public welfare pursuant to M.G.L. c. 118E and in accordance with Title XIX of the Federal Social Security Act.

Medical Assistance Program. The medicaid program, the Veterans Administration health and hospital programs and any other medical assistance program operated by a governmental unit for persons categorically eligible for such program.

Medical Hardship. A situation in which major expenditures for health care and/or income loss stemming from an individual's medical condition have depleted or can reasonably be expected to deplete the financial resources of the individual to the extent that he or she will be unable to pay for needed medical services, as described in a hospital's credit and collection policy.

Medical Service Corporation. A corporation established for the purpose of operating a nonprofit medical service plan as provided in M.G.L. c. 176B.

Medically Necessary Service. A service that is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the recipient that endangers life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity. Medically necessary services shall include inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act. Medically necessary services shall not include:

(a) nonmedical services, such as social, educational, and vocational services;
(b) cosmetic surgery;
(c) canceled or missed appointments;
(d) telephone conversations and consultations;
(e) court testimony;
(f) research or the provision of experimental or unproven procedures including, but not limited to, treatment related to sex-reassignment surgery, and pre-surgery hormone therapy; and
(g) the provision of whole blood; provided, however, that administrative and processing costs associated with the provision of blood and its derivatives shall be payable.

Medicare Program. The medical insurance program established by Title XVIII of the Social Security Act.

Provider. Any person, corporation, partnership, governmental unit, state institution and other entity qualified under the laws of the commonwealth to perform or provide health care services.

Private Sector. As defined by the regulations of the Commission.

Private Sector Charges. Gross patient revenues based on all charges to purchasers and third party payors, including charges under MGL c. 152, exclusive of charges for services to publicly aided patients, charges under Titles XVIII and XIX, free care, reduced by all income, recoveries and adjustments, and bad debt, reduced by all income, recoveries and adjustments.

Publicly Aided Patient. A person who receives hospital care and services for which a governmental unit is liable in whole or in part under a statutory program of public assistance.

Purchaser. A natural person responsible for payment for health care services rendered by a hospital.

7.02: continued

Self-Insurance Health Plan. A plan which provides health benefits to the employees of a business, which is not a health insurance plan, and in which the business is liable for the actual costs of the health care services provided by the plan and administrative costs.

Shortfall Amount. The amount equal to the difference between the total allowable free care costs for all hospitals and the revenue available for reimbursement of free care to the hospitals.

Total Patient Care Costs. Patient care cost as reported by the hospital pursuant to the instructions of the Department.

Uncompensated Care Percentage. The ratio of each individual hospital's private sector charges for the fiscal year to the total of all hospitals' private sector charges for such fiscal year.

Uncompensated Care Percentage. As defined and calculated pursuant to M.G.L. c. 6B, § 11(2).

Uninsured Patient. A patient who is not covered by any of the following:

(a) a health insurance plan including the medicare program or an individual or group contract or other plan providing coverage of health care services which is issued by a health insurance company, a hospital service corporation, a medical service corporation or a health maintenance organization; or

(b) a self insurance health plan including a plan which provides health benefits to the employees of a business, which is not a health insurance plan, and in which the business is liable for the actual costs of the health care services provided by the plan and the administrative costs; or

(c) a medical assistance program including the medicaid program, the Veterans Administration health and hospital program and any other assistance program operated by a governmental unit for persons categorically eligible for such program.

A patient shall not be deemed uninsured if such patient has a policy of health insurance or is a member of a health insurance or benefit program which requires such patient to make payment of deductibles, or co-payments, or fails to cover certain medical services or procedures.

7.03: Reporting Requirements

(1) Required Reports and Filing Dates. Each acute care hospital shall comply with the following reporting requirements:

(a) DMS Form UC-92 due no later than 45 days after the last day of the fiscal month for which the report is being submitted;

(b) Its manual or any document, in whatever form, setting forth the hospital's classification of persons presenting for unscheduled treatment, the urgency of treatment associated with each such classification, the location or locations at which such patients might present themselves and any other relevant and necessary instruction to hospital personnel who routinely see patients presenting for unscheduled treatment regarding said classification system. The manual or document must list those classifications which qualify as emergency care under 117 CMR 7.00. Such manual or document must be filed with the department by May 15, 1992. Any subsequent amendments thereto shall be filed with the department at least 60 days prior to the effective date of the amendment. Such manual or document must be accepted for filing by the department before it is relied upon by the hospital in claiming any payment from the pool for emergency care;

(c) Its credit and collection policy, as defined by 117 CMR 7.02. The policy which has been filed pursuant to 117 CMR 2.03 shall satisfy the requirements of 117 CMR 7.00. Any subsequent amendments thereto shall be filed with the Department at least 60 days prior to the effective date of the amendment;

7.03: continued

(d) Each acute hospital shall, upon request, file in a format specified by the Department, information regarding its bad debt write-offs and free care write-offs. This information may include, but shall not be limited to: for inpatient accounts, type of write-offs (*i.e.* bad debt or free care), billing number, medical record number, date of admission and/or date of discharge, total amount of charges and amount of charges written off; for outpatient services, type of write-off, billing number, medical record number, date of service, type of outpatient service, total amount of charges and amount of charges written off. Each acute hospital shall, upon request, provide the Department or its agent with access to patient account records and related reports for the purpose of abstraction by the Department or its agent of additional data elements beyond those specified above;

(e) Each acute hospital shall file or make available information which is required by 117 CMR 7.03 or which the Department deems reasonably necessary for implementation of 117 CMR 7.00 in accordance with time limits set forth in 117 CMR 7.03, or within 15 days from the date of request from the Department, unless a different time is specified in the request. The Department may, for cause, extend the filing date for the submission of reports, schedules, reporting forms, budgets, information, books and records. Any request for an extension must be made in writing and submitted to the Department in advance of the filing date.

(2) Enforcement of Reporting Requirements. If a hospital fails to meet the reporting requirements of 117 CMR 7.03(1), the Department may determine that the hospital does not incur any free care expenses for the period for which it fails to meet the reporting requirements. If the Department makes such a determination it will adjust the hospital's liability to or from the uncompensated care pool as calculated pursuant to 117 CMR 7.04 to reflect this determination.

7.04: Payments to and From the Uncompensated Care Pool

Each acute hospital shall make payments to or receive payments from the uncompensated care pool in accordance with 117 CMR 7.04.

(1) Payments to the Department or its agent shall be made in accordance with instructions from the Department.

(2) If any part of the hospital's payment is not made on the due date, the Department shall assess a 5% surcharge on the amount that is overdue. The Department shall reduce this surcharge to 1% of the amount that is overdue if the hospital satisfies and documents the following conditions:

(a) The hospital has applied for and been denied a sufficient working capital loan by a qualified lending institution within the past 90 days; and

(b) The amount overdue exceeds 2% of the hospital's average monthly revenues for the prior six months. The hospital must apply for such surcharge reduction within 15 days of receiving the initial assessment of the surcharge, and must document the above conditions within 60 days of receiving the initial assessment of this surcharge.

(3) Gross Payments to or from the Uncompensated Care Pool. Each hospital's payments to and from the uncompensated care pool shall be based on gross liability to and from the uncompensated care pool. The Department will determine the gross liability of a hospital to or from the uncompensated care pool as follows:

(a) The hospital shall make a payments of its gross liability to the uncompensated care pool in accordance with the invoices from the Department. The Department shall make the appropriate gross payment from the uncompensated care pool to the hospital.

(b) The hospital's fiscal year gross liability to the uncompensated care pool shall be calculated as follows:

1. for the time period of October 1, 1991 to September 30, 1992, inclusive, it will be as set forth in St. 1991, c. 495, § 54;

2. for the time period beginning on October 1, 1992, it will equal the product of each hospital's uncompensated care percentage and the private sector liability to the uncompensated care pool, determined by the general court.

7.08: continued

3. State who in the hospital is responsible for making decisions regarding eligibility for free care or medical hardship under 117 CMR 7.08(2)(d).

(b) When specifying the criteria and procedures that a hospital uses to determine medical hardship pursuant to 117 CMR 7.08(2)(d), the hospital's Credit and Collection Policy must, at a minimum, address whether it considers the following factors, and if so how:

1. The amount of the patient's family income – adjusted for extraordinary expenses (such as high child care or parent costs) – relative to the amount of his/her health care expenses and health insurance premium costs;
2. The existence and availability of family assets;
3. The patient's future income earning capacity, especially where the patient's ability to work in the future may be limited as a result of illness; and
4. The patient's ability to make payments over an extended period of time.

7.09: Criteria for Notification of the Availability of Free Care to Patients

117 CMR 7.09 specifies the criteria that hospitals must meet regarding notification of the availability of free care and/or public assistance programs to patients. Hospitals shall employ the following procedures to notify patients of the availability of free care and to assist patients for possible eligibility for public assistance programs.

(1) Notification.

(a) Posting. The hospital shall post signs, in the inpatient, outpatient and emergency admissions/registration areas and in business office areas that are customarily used by patients, that conspicuously inform patients of the availability of free care and where to apply for such are. Such signs shall be in large print.

(b) Individual Notice. A hospital shall provide individual notice of availability of free care where a hospital has been given an indication that a patient will incur charges, exclusive of personal convenience items or services, that may not be paid in full by third party coverage. The individual notice shall specify the income and resource criteria the hospital uses in order to determine patient eligibility for free care, and the time it takes the hospital to make such a determination and include also information where patients can apply for free care. A copy of such notice must be included in the hospital's Credit and Collection Policy.

(c) A hospital shall include a notice of free care as described in 117 CMR 7.09(1)(b) in its initial bill. In all other written collection action the hospital shall include a brief message of the availability of free care and other types of assistance and what telephone numbers to call for more information.

(d) All signs and notices specified in 117 CMR 7.09(a), (b) and (c) shall be translated into language(s) other than English if such language(s) is primarily spoken by 10% or more of the residents in the hospital's service area.

(2) Assistance. The hospital shall advise and assist patients concerning the patient's possible eligibility for public assistance programs. The policy and procedures for advising such patients shall include, at a minimum, the provision to patients of information concerning the availability of Medical Assistance programs and the distribution of brochures for public assistance programs and the local legal services, if such brochures are made available to the hospital by Medicaid and the local legal services agency.

7.10: Documentation and Audit: Free Care Accounts

(1) Each hospital shall maintain auditable records of its activities made in compliance with the criteria and requirements of regulation 117 CMR 7.00. The hospital's free care write-offs as reported on RSC-404, RSC-403, DMS Form UC-92, DMS Form UC-93 or any successor form, that has been filed, shall be documented. Each hospital's free care write-offs, shall be accompanied, at a minimum, by documentation of all efforts made by the hospital to determine free care eligibility.

7.10: continued

(2) The Department's criteria for documentation of free care accounts shall be detailed in a separate administrative information bulletin issued pursuant to 117 CMR 7.12.

(3) The Department's audit procedures regarding free care accounts and the Department's schedule of audit adjustments regarding deficiencies in documentation shall be detailed in a separate administrative information bulletin issued pursuant to 117 CMR 7.12. The audit adjustments will reflect the degree of non-compliance with the Department's criteria for documentation of free care accounts.

7.11: Utilization Review

(1) In order to encourage maximum efficiency and appropriateness in the utilization of acute hospital services there shall be an utilization review for hospital admissions and continued acute hospital stays, as well as ancillary services and outpatient services.

(2) The utilization review may be conducted by the Department or its designee.

(3) Nothing set forth in 117 CMR 7.11 shall be construed as affecting the calculations of payments to and from the pool as otherwise provided for in 117 CMR 7.04.

(4) Utilization review shall be conducted for those hospital admissions and continued acute hospital stays which are included in the calculation of the gross liability of a hospital from the uncompensated care pool. An utilization review shall not be conducted in those instances where another third party payor has conducted an utilization review.

(5) Utilization review shall be administered and conducted as set forth in the "Provider Reference Guide" which is incorporated herein by reference. All terms and conditions set forth in the "Provider Reference Guide" shall have the same force and effect as if fully set forth herein. All changes or amendments to the "Provider Reference Guide" shall be governed by the same procedural requirements as are the rules and regulations of the department. The effective date of 117 CMR 7.00 set forth in 117 CMR 7.01(1)(c)5 shall be construed consistently with and effectuating the dates set forth in the "Provider Reference Guide."

(6) Upon exhaustion of appeal of a review determination described in the "Provider Reference Guide" a hospital may seek an administrative review by the Department. The procedure of such administrative review by the Department shall be governed by 117 CMR 7.05(2) and (3). Such procedure shall be adopted, as appropriate, to the unique requirements of the utilization review program.

7.12: Administrative Information Bulletins

The Department may, from time to time, issue administrative information bulletins to clarify its policy upon and understanding of substantive provisions of 117 CMR 7.00. In addition, the Department may issue administrative information bulletins which specify the information and documentation necessary to implement 117 CMR 7.00.

7.13: Severability

The provisions of 117 CMR 7.00 are hereby declared to be severable if any such provisions or the application of such provisions to any hospital or circumstances shall be held to be invalid or unconstitutional, and such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 117 CMR 7.00 or the application of such provisions to hospitals or circumstances other than those held invalid.

REGULATORY AUTHORITY

117 CMR 7.00: M.G.L. c. 118E, §§ 6(a) and 15(9) as amended by St. 1991, c. 495.

7.04: continued

(c) Pool's gross liability to the hospital shall be determined as follows:

1. pool's gross liability to each hospital shall be equal to the total allowable free care costs of the hospital less the pool shortfall allocation;

2. the total allowable free care costs shall be the product of the cost to charge ratio and the gross free care charges less free care income, related bad debt recoveries and audit results. Gross free care charges shall not include any sums attributable to free care for which reimbursement is available from other sources including, but not limited to, the medicare program, irrespective of whether such reimbursement has been collected by a hospital. Medicare free care shall be considered reimbursable by the pool to the extent allowed by 117 CMR 7.02;

3. the pool shortfall allocation shall be the lesser of the product of the ratio of the hospital's total patient care costs to the total patient care costs of all hospitals, multiplied by the shortfall amount or the amount equal to the total allowable free care costs of the hospital.

(d) If a hospital is unable to determine the appropriate segregation of bad debt related to emergency care from the bad debt related to non emergency bad debt for any fiscal year, then the Department shall make an appropriate estimate. If a hospital is unable to determine recoveries, the Department shall estimate the amount of recoveries of bad debt which is attributable to bad debt arising from the emergency care to uninsured patients on the basis of the ratio of the total of the bad debt recoveries to the total of the bad debt.

(4) Interim Calculation of a Hospital's Payment to or from the Uncompensated Care Pool. In order to facilitate timely payments to and from the uncompensated care pool, the Department will from time to time calculate each hospital's payment to and from the uncompensated care pool for a fiscal year by estimating its liability to and from the uncompensated care pool and crediting any payments made to and from the uncompensated care pool for the fiscal year in question. The calculation shall be made according to the following guidelines:

(a) The Department shall notify each hospital of the methodology used to calculate payments and the results of the calculation for the hospital;

(b) If a hospital has not reported data required to calculate the hospital's net payment, the Department may substitute for the required data elements relevant industry averages, prior year reports by the hospital, or other data the Department deems appropriate;

(c) The Department shall adjust payments to reflect the availability of funds;

(d) The Department may adjust payments to reflect uncompensated care pool expenses for activities authorized in M.G.L. 118F, § 15.

(5) Final Calculation of a Hospital's Payment to and from the Uncompensated Care Pool. The final settlement between the uncompensated care pool and a hospital for a fiscal year shall comply with the guidelines set forth in 117 CMR 7.04(4) and it shall be as follows:

(a) It shall take place upon completion of the relevant audit and calculations by the Department and the commission, for that fiscal year;

(b) It shall be determined using actual gross patient service revenues, final cost to charge ratios and actual free care charges, each having been adjusted for any audit findings;

(c) It shall include reconciliation of any interim payments and estimated liabilities to and from the uncompensated care pool.

(6) Special Calculation for the Settlement Between the Hospitals and the Pool for the Fiscal Year of October 1, 1991 to September 30, 1992. In order to facilitate timely settlement of payments to and from the pool and to promote fair distribution of pool funds among the participating hospitals, the Department will, for the time period of October 1, 1991 to September 30, 1992, determine the gross free care charges eligible for reimbursement before adjustment as follows:

(a) For the time period of October 1, 1991 to March 31, 1992, for those hospitals which are not able to determine the amount of bad debt arising from emergency care to the uninsured, the estimate of the amount of the free care charges eligible for reimbursement before adjustment shall be calculated pursuant to the following rules and formulas:

1. the time period of October 1, 1991 to March 31, 1992 shall be designated as "P1";